

# USAF REFRACTIVE SURGERY APPLICATION - Warfighter

For application IAW USAF-RS Warfighter Program Management

(READ ALL INSTRUCTIONS PRIOR TO COMPLETING FORM)

This form and other USAF-RS Tools are available on AF Knowledge Exchange (DotMil) <https://kx.afms.mil/USAF-RS>

or Public Access <http://airforcemedicine.afms.mil/USAF-RS>

Application

Date:

## APPLICANT INFORMATION

Last Name First Name Middle Initial

SSN (last 4) DOB Age

Grade/Rank Primary AFSC Sex ☐ Male ☐ Female

Duty Status ☐ AD ☐ AGR ☐ AFRes ☐ ANG ☐ Other MAJCOM

Total # months of remaining AD retainability (eligible for elective surgery benefits)

**NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.**

Unit/Squadron & Office Symbol Phone (DSN)

Street

Base / State Zip + 4

Duty E-mail

Planned RS treatment Location

Preferred RS Treatment ☐ Advanced Surface Ablation (ASA) (PRK, Epi-LASIK, LASEK, WFG-PRK) ☐ Intra-Stromal Ablation (ISA) (LASIK, FS-LASIK, WFG-LASIK) ☐ Any Approved USAF RS Procedure

Applicant's Signature

This application form is for use by **USAF Warfighter personnel** seeking RS Treatment at a DOD (military) facility.

*Aviation / Aviation Related Special Duty (AASD) personnel or AF members seeking treatment at a civilian RS center, please refer to the USAF-RS website for specific application requirements and forms.*

## FOR USAF-RS WARFIGHTER PROGRAM MANAGER (WPM) ENDORSEMENT ONLY

Disposition Date Permission to Proceed? ☐ Yes ☐ No

Reviewing Officer's Name/Rank  
Reviewing Officer's Signature

## MANDATORY QUESTIONS (APPLICANT MUST INITIAL)

- Initials I am responsible for reading and complying with the policy and guidelines of USAF-RS Program available at: (DOD Dot.mil) <https://kx.afms.mil/USAF-RS> or (Public Access) <http://airforcemedicine.afms.mil/USAF-RS>.
- Initials I understand I am NOT authorized to undergo refractive surgery until I have received "Permission to Proceed" authorization from the USAF-RS Warfighter Program Manager. If granted "Permission to Proceed" authorization, the treatment is not guaranteed. Final decision to treat will be made by the treating refractive surgeon.
- Initials I understand my Commander's Authorization expires 6 months from the date of their signature. If I am unable to complete treatment within this authorized period, I obtain a new Commander's Authorization which must be submitted to the Aviation Program Manager. A valid authorization is mandatory for USAF-RS treatment.
- Initials I must inform my primary care manager and eye care provider upon surgery treatment, any required follow-up care, and in the event of any complications. If follow-up examinations as required by policy is not accomplished, I may be restricted from duty until in compliance.
- Initials I understand the final decision whether to perform RS and/or recommended technique will be determined by my treating refractive surgeon. At any time, I may be disqualified for refractive surgery or I may elect not to undergo treatment.
- Initials If I am disqualified as a RS candidate, I am not eligible for reimbursement of expenses incurred for travel to/from the DoD RS center, including, but not limited to travel, meals, and lodging. (This does not apply if I am unit-funded.)
- Initials I understand I may require or continue to require reading and/or distance prescription correction for best vision after surgery. Furthermore, I understand there is a chance I cannot be fit with contact lenses for vision correction, if desired, after RS.
- Initials I understand RS is a non-reversible, alteration of my vision and, even with optimal outcome, my vision may change over time.
- Initials I understand my vision will require time to fully recover following RS Surgery and there is a risk of not meeting relevant vision standards after RS. Therefore, I may be disqualified from certain careers, duties, or even continued military service.

**Submission of application package:** If choosing an AF CRS Center, contact and submit completed package to desired RS Center.

If choosing a non-AF RS center, submit completed package for review to: the WPM - Joint Service Refractive Surgery Center, Lackland AFB.

AF RS CENTER	DSN - Voice	COM - Prefix	FAX	Email Address
Lackland AFB	554-2010 / 3495	210-292-xxxx	xxx-2313 / 2813	<a href="mailto:WHMC-CRS@lackland.af.mil">WHMC-CRS@lackland.af.mil</a>
Air Force Academy	333-5958	719-333-xxxx	xxx-9774	<a href="mailto:10mdg.lasereveclinic@usafa.af.mil">10mdg.lasereveclinic@usafa.af.mil</a>
Andrews AFB	857-8777	240-857-xxxx	xxx-8226	<a href="mailto:779MDG/wfec/andrewsafb@afncr.af.mil">779MDG/wfec/andrewsafb@afncr.af.mil</a>
Keesler AFB	591-0567	228-376-xxxx	xxx-0155	<a href="mailto:81mdg/refractiveurgery@keesler.af.mil">81mdg/refractiveurgery@keesler.af.mil</a>
Travis AFB	799-3146	707-423-xxxx	xxx-3529	<a href="mailto:60msgsgcxe.laser.center@travis.af.mil">60msgsgcxe.laser.center@travis.af.mil</a>
Wright-Patterson AFB	986-0970 / 1447	937-656-xxxx	xxx-0973	

WARFIGHTER CRS APPLICATION: OCULAR/REFRACTIVE STATUS					(TO BE COMPLETED BY THE APPLICANT'S EYE CARE PROVIDER)														
Examination data submitted for Permission-to-Proceed consideration must have been accomplished within 6 months of application date.																			
Evaluation Date		Last Name			First Name			Middle Initial		SSN (last 4)									
<div>Pachymetry (if available locally)</div> <table> <tr> <td>OD</td> <td></td> <td>microns</td> </tr> <tr> <td>OS</td> <td></td> <td>microns</td> </tr> </table>										OD		microns	OS		microns	<div>Contact Lens Wear History</div> <div> Type Worn <input type="checkbox"/> N/A    How many days since last worn?  <input type="checkbox"/> SCL    <input type="checkbox"/> RGP </div>			
										OD		microns							
										OS		microns							
										Prior to any evaluation/CRS treatment - contact lens use must be discontinued. SCL for minimum 14 days. HCL / RGP for minimum 90 days									
<div>Prior Manifest Refraction</div> <div>Must be &gt;12 months prior to current exam</div> <table> <tr> <td>OD</td> <td></td> <td>-</td> <td>X</td> <td></td> </tr> <tr> <td>OS</td> <td></td> <td>-</td> <td>X</td> <td></td> </tr> </table>					OD		-	X		OS		-	X		<div>Patient to fill out:</div> <div>CONTRAINDICATIONS / WARNINGS</div> <div> Age &lt; 21 <input type="checkbox"/> Yes <input type="checkbox"/> No  Pregnant /Nursing during last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No  Diabetes Mellitus <input type="checkbox"/> Yes <input type="checkbox"/> No  Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No  Severe dry eyes / atopic disease <input type="checkbox"/> Yes <input type="checkbox"/> No  Electronic Pacemaker/similar cardiac device <input type="checkbox"/> Yes <input type="checkbox"/> No  Autoimmune disease / immunodeficiency <input type="checkbox"/> Yes <input type="checkbox"/> No  Psoriasis <input type="checkbox"/> Yes <input type="checkbox"/> No  Dermatitis Herpetiformis <input type="checkbox"/> Yes <input type="checkbox"/> No  Pemphigus Vulgaris <input type="checkbox"/> Yes <input type="checkbox"/> No  Vitiligo <input type="checkbox"/> Yes <input type="checkbox"/> No  Current use of:  Accutane (Isotretinoin) <input type="checkbox"/> Yes <input type="checkbox"/> No  Imitrex (Sumatriptan) <input type="checkbox"/> Yes <input type="checkbox"/> No  Cardarone (Amiodarone) <input type="checkbox"/> Yes <input type="checkbox"/> No  Steroids <input type="checkbox"/> Yes <input type="checkbox"/> No  INH <input type="checkbox"/> Yes <input type="checkbox"/> No </div>				
OD		-	X																
OS		-	X																
<div>MANIFEST REFRACTION TO BEST VISUAL ACUITY</div> <table> <tr> <td>OD</td> <td></td> <td>-</td> <td>X</td> <td>20/</td> </tr> <tr> <td>OS</td> <td></td> <td>-</td> <td>X</td> <td>20/</td> </tr> </table>					OD		-	X	20/	OS		-	X	20/					
OD		-	X	20/															
OS		-	X	20/															
<div>CORNEAL TOPOGRAPHY (Explain Abnormal in comments)</div> <table> <tr> <td>OD</td> <td>OS</td> </tr> <tr> <td><input type="checkbox"/> Normal    <input type="checkbox"/> Abnormal</td> <td><input type="checkbox"/> Normal    <input type="checkbox"/> Abnormal</td> </tr> </table>					OD	OS	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<div>Eye Care Provider to fill out:</div> <div> &gt; 0.50 D change in sph or cyl in past 12 mos. <input type="checkbox"/> Yes <input type="checkbox"/> No  IOP &gt; 21 / glaucoma (or suspect) <input type="checkbox"/> Yes <input type="checkbox"/> No  Keratoconus or corneal irregularity <input type="checkbox"/> Yes <input type="checkbox"/> No  History of HSV / HZV keratitis <input type="checkbox"/> Yes <input type="checkbox"/> No  Active Ophthalmic disease <input type="checkbox"/> Yes <input type="checkbox"/> No  Corneal scars/ Neovascularization <input type="checkbox"/> Yes <input type="checkbox"/> No  Corneal NV &gt; 2mm from limbus <input type="checkbox"/> Yes <input type="checkbox"/> No  Visually significant cataract <input type="checkbox"/> Yes <input type="checkbox"/> No  Hx of prior refractive surgery <input type="checkbox"/> Yes <input type="checkbox"/> No  Other pertinent ocular history <input type="checkbox"/> Yes <input type="checkbox"/> No  I have read and will comply IAW AFI 48-123, Chapter 12 dated 24 September 2009 <input type="checkbox"/> Yes <input type="checkbox"/> No  I am a USAF Certified RS eyecare provider <input type="checkbox"/> Yes <input type="checkbox"/> No  Will a USAF Certified RS eyecare provider be available for post operative care? <input type="checkbox"/> Yes <input type="checkbox"/> No  In your professional opinion, does the applicant meet USAF RS criteria? <input type="checkbox"/> Yes <input type="checkbox"/> No </div>										
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					<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal													
<div>COMMENTS:</div>																			
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